

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03859

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03852

1. DECEASED-NAME (Type or Print)				First Middle Last				2a. DATE KNOWN OF DEATH				2b. HOUR											
Minnie Florence Ahalt								Month Day Year				M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR									
Female		White		Oct. 13, 1886		82 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year		10:30 AM									
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH											
Maryland				U.S.A.								Frederick Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Frederick				Frederick Mem. Hosp.				Housekeeper				Own home											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER							
Maryland				Frederick				Middletown				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Quebec School Rd. RFD2											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
First Middle Last				First Middle Last																			
Hezekiah Poole				Elizabeth Baker																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No								Mrs. Grace Miller				Middletown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
<u>Fracture Humerus (R); UREMIA; OBESITY; ASCVD.</u>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
				HOUR A.M. P.M. <u>3/19 1969</u>				<u>Fell</u>															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
				<u>Home</u>				<u>Middletown</u>				<u>Frederick</u>				<u>MD</u>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED							
<u>R. J. Thomas</u>																<u>3-28-69</u>							
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)																			
R. J. Thomas, M. D.				812 Tollhouse Ave				Fred., Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
<u>Burial</u>				<u>March 31, 69</u>				<u>Lutheran Cemetery</u>				<u>Middletown Fred. Md.</u>											
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
<u>Gladhill Co.</u>				<u>Middletown, Maryland</u>				<u>APR 1 1969</u>				<u>Charles Judge</u>											

STATE OF TEXAS  
COUNTY OF DALLAS

03859

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03859

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03860										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03853																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
Editha Ann Arnold										March 18 1969										5 P.M.																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										November 11, 1879										89 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										U.S.A.																				Frederick										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Frederick										Monocacy Hall Nursing Home										Housekeeper										Own home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																													
Maryland										Frederick										Burkittsville										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										Gapland Rd.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
David Arnold										Mary Ann Wiener																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										220-44-6474-J1										Mrs. Gertrude Ausherman										Burkittsville Maryland																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) 4124 Coronary thrombosis																														1 min																													
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Anteroseptal CVD																				10 years																													
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
Cerebral thrombosis January 1969																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																																											
22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to 18 Mar, 1969, that (I) (we) lost the deceased alive on 18 Mar, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
James E. Stoner, Jr.										3/19/69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
JAMES E. STONER, JR.										WALICKERSVILLE, Md 21793																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										Mar. 21, 1969										Union Cemetery										Burkittsville Fred. Md.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Gladhill Company										Middletown, Md.										MAR 24 1969										James Judge																													

03860

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03861										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03854																																																											
1. DECEASED-NAME										20. DATE OF DEATH										2b. HOUR																																																											
(Type or print)										Month Day Year										2b. HOUR																																																											
KATE M. BIDDLE										MARCH 28 1969										6:30 M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years)										IF UNDER 1 YEAR										IF UNDER 24 HRS																													
Female										White										July 18, 1878										90										MONTHS										DAYS										HOURS										MIN									
70. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. COUNTY OF DEATH										Md.																													
Michigan										U. S. A.										WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										Frederick																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Frederick										Monocacy Hall Nursing Home										Housewife																																																											
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																																							
Maryland										Frederick										Frederick										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										911 Motter Place																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
Charles H. Morse										Julia Sessions										No																				Mrs. N. Edward Lightner, 911 Motter Place										Frederick, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
4124										DUE TO, OR AS A CONSEQUENCE OF										Cardiac arrest										10 min																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF										Arteriosclerotic cardiovascular disease										5 years																																																	
										DUE TO, OR AS A CONSEQUENCE OF										Cerebrovascular disease with dementia										5 years																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21a. ACCIDENT WAS UNDERLYING										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)																																																											
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										HOUR A.M. Month Day Year																																																																					
										P.M. 19																																																																					
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No.										City or Town										County										State																			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																																																																															
22a. I certify that (I) (this hospital) attended the deceased from March 1964, to March 26 1969, that (I) (we) lost saw the deceased alive on March 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
LeRoy T. Davis										March 27, 1969																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
LeRoy T. Davis, M.D.										228 N. Market St. Frederick, Maryland																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town)										(County)										(State)																													
Burial										March 28, 1969										Mount Olivet Cemetery										Frederick										Frederick										Md.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
M. R. Etchison & Son, Frederick, Md.										APR 1 1969																																																																					



NAME OF PERSON		ADDRESS		CITY		STATE		COUNTRY	
				</					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be removed from the certificate, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
RUHLAND		C.		BOYER	March	Day 3	Year 1969	1 p. M.
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male	White		February 4, 1905		64 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland	U.S.A.				Frederick			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Old Braddock	Old Braddock		retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland	Frederick		Old Braddock				Route 5	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Howard		C.		Boyer	Caroline			Ruhland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		213 05 6608		Mrs. Evelyn		Mrs. Caroline Boyer, Route 5, Frederick, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>Diabetes mellitus</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 68, to Mar 3, 19 69, that (I) (we) last saw the deceased alive on 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
Willis J. Riddick		March 4, 1969		Frederick Medical Center, Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 6, 1969		Mt. Hope Cemetery		Woodsboro Frederick Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
M. R. Etchison & Son, Frederick, Md.		Fidelity		MAR 5 1969		Charles Judge		

03882

03882

MINISTRY OF HEALTH

1944

1. Name of patient: [illegible]  
2. Date of birth: [illegible]  
3. Sex: [illegible]  
4. Address: [illegible]  
5. Occupation: [illegible]  
6. Date of admission: [illegible]  
7. Date of discharge: [illegible]  
8. Name of attending physician: [illegible]  
9. Name of hospital: [illegible]  
10. Name of doctor: [illegible]

11. Name of nurse: [illegible]  
12. Name of pharmacist: [illegible]  
13. Name of dietitian: [illegible]  
14. Name of social worker: [illegible]  
15. Name of psychologist: [illegible]  
16. Name of psychiatrist: [illegible]  
17. Name of audiologist: [illegible]  
18. Name of optometrist: [illegible]  
19. Name of dentist: [illegible]  
20. Name of other specialist: [illegible]

21. Name of laboratory: [illegible]  
22. Name of X-ray department: [illegible]  
23. Name of pathology department: [illegible]  
24. Name of radiology department: [illegible]  
25. Name of other department: [illegible]

26. Name of hospital: [illegible]  
27. Name of city: [illegible]  
28. Name of state: [illegible]  
29. Name of country: [illegible]  
30. Name of continent: [illegible]

31. Name of hospital: [illegible]  
32. Name of city: [illegible]  
33. Name of state: [illegible]  
34. Name of country: [illegible]  
35. Name of continent: [illegible]

36. Name of hospital: [illegible]  
37. Name of city: [illegible]  
38. Name of state: [illegible]  
39. Name of country: [illegible]  
40. Name of continent: [illegible]

41. Name of hospital: [illegible]  
42. Name of city: [illegible]  
43. Name of state: [illegible]  
44. Name of country: [illegible]  
45. Name of continent: [illegible]

46. Name of hospital: [illegible]  
47. Name of city: [illegible]  
48. Name of state: [illegible]  
49. Name of country: [illegible]  
50. Name of continent: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03863 CERTIFICATE OF DEATH 03856										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Anna			M. Burgess			March 31 Day 1969 Year		3:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Sept. 15-1882		86 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U. S. A.				Frederick		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Frederick			Frederick Mem. Hospital			Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Frederick		New Market		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
George W. Burgess			Mary A.L. Lehr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			217-12-1779		Mrs. Charles W. Wiles-Brunswic-Md. 21716					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ch. Congestive failure due to A-S. heart dis</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1962</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Probable intraabdominal malignancy</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>19 March, 1969</u> , to <u>31 Mar, 1969</u> , that (I) (we) last saw the deceased alive on <u>31 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Charles H. Conley, Jr. M.D.</u>					22c. DATE SIGNED <u>Mar. 31-1969</u>					
22d. PHYSICIAN'S NAME (Type) Charles H. Conley-Jr.					22e. ADDRESS Prof. Bldg.-Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Apr. 3-1969		Methodist Cemetery		New Market-Md. 21774				
24. FUNERAL DIRECTOR <u>Elwood T. M.R. Etchison &amp; Son</u>			ADDRESS <u>Whitmore</u> Frederick, Md. 21701			25a. REC'D BY REGISTRAR DATE <u>APR 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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OFFICE OF THE

DATE: 10-10-1962

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>Anna-also Annie</b> First <b>M.</b> Middle <b>Cavell</b> Last						2a. DATE OF DEATH <b>March</b> Month <b>13</b> Day <b>69</b> Year			2b. HOUR <b>3:15</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 20-1887</b>		6. AGE (In years lost birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			Md.			
10. CITY OR TOWN OF DEATH <b>Braddock Hgts.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Vindobona Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 4</b>			
14. FATHER'S NAME First <b>Powell</b> Middle Last <b>Ball</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Not available</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217-10-9632D</b>		17. INFORMANT Address <b>Mrs. Dorothy Shaff-Rt. 4-Frederick, Md. 21701</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>												
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic vascular disease</b>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1969</b> to <b>March 13, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>L. Roy T. Davis</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Mar. 14-1969</b>				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <b>Prof. Bldg.-Frederick, Md. 21701</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Mar. 17-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick- Frederick- Md.</b>				
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>						ADDRESS <b>Frederick, Md. 21701</b>			25a. REGISTRAR DATE <b>MAR 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William C. Under</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03858

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Walter Rhodes Clark						March 1, 1969			2 a.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		Feb. 13, 1909			60 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Frederick Md.				
Franklin Va.		USA.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick Md.			709 Magnolia Ave.			Mechanical Engineer			Ft Detrick		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		709 Magnolia Ave.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Herman Clark						Elizabeth Rhodes Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO					244-10-8765		Mrs. Hildredh S. Clark 709 Magnolia Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>White (Mucous) Coronary occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> to <u>3/1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert S. Hughes</u>						DEGREE M.D.			22c. DATE SIGNED March 1, 1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Dr. Robert S. Hughes						700 Montclair Avenue Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-4-1969			Hillside Memorial Gardens			Plymouth, North Carolina		
24. FUNERAL DIRECTOR <u>Robert E. Dailey &amp; Son</u>						ADDRESS Frederick, Maryland			25a. REC'D BY REGISTRAR DATE <u>MAR 4 1969</u>		
									25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03866					03859				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last LUCY VIRGINIA CLINE					2a. DATE OF DEATH Month Day Year March 19 1969			2b. HOUR 5P M	
3. SEX female		4. RACE white		5. DATE OF BIRTH Oct. 21, 1892		6. AGE (In years last birthday) 76 YRS.		7. COUNTY OF DEATH Frederick Md.	
7a. BIRTHPLACE (State or foreign country) Fred. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH Rural-Myersville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route # 1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Myersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route # 1			14. FATHER'S NAME First Middle Last Charles W. Rice			15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Derr Rice			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) - - - - -		17. INFORMANT Address John H. Cline, Myersville, Md. Rt 1				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive vascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden death</u> <u>10-20 yrs</u> <u>10-20 yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1963</u> , to <u>Mar 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. S. Stauffer</u> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Mar 21, 1969</u>
22d. PHYSICIAN'S NAME (Type) R. S. STAUFFER					22e. ADDRESS Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE <u>Mar. 22, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion U. M.</u>		23d. LOCATION (City or Town) (County) (State) <u>Myersville, Fred. Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Paul F. Bittle</u> ADDRESS <u>Myersville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 24 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03860	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										03860	
1. DECEASED-NAME (Type or Print)			First MARK		Middle WARD		Last CROWLEY			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 3 23 1969	
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH June 1, 1952		6. AGE (In years last birthday) 16 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 3 23 1969		
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick, Md.					
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Fred. Mem. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route # 6		
14. FATHER'S NAME First Middle Last Ward William Crowley			15. MOTHER'S MAIDEN NAME First Middle Last Anna Ruth			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16b. SOCIAL SECURITY NO. 217-56-1395			17. INFORMANT ADDRESS Mr. Ward W. Crowley Rt. # 6 Frederick, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHED SKULL</u> 8199 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>LACERATED BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 6:00 P.M. 3/23 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) AUTO ACCIDENT					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HIGHWAY		21f. LOCATION Street or R.F.D. No. City or Town County State GAMARILL PARK RD. Frederick MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Robert J. Thomas, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3-23-69			
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-26-1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION (City or Town) (County) (State) Auto, West Virginia			
24. FUNERAL DIRECTOR Robert E. Bailey & Son				ADDRESS Frederick, Maryland				25a. REC'D BY REGISTRAR DATE MAR 26 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

ROBERT J. THOMAS, M.D.  
812 TOLL HOUSE AVENUE  
FREDERICK, MARYLAND

03280

FOR NAME  
REMARKS

ROBERT J. THOMAS, A.D.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03868										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03861																			
CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or print)					First Lucy					Middle Ann					Last Cutright					2a. DATE OF DEATH					2b. HOUR														
															3 Month					30 Day					69 Year					11:aM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.														
Female					White					May 19, 1881 June 17, 1891					77 YRS.					MONTHS					DAYS					HOURS					MIN				
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																								
Maryland					U.S.										Frederick										Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																			
Frederick					Md. Odd Fellows Home										Retired School Teacher																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER																			
Maryland					Wicomico										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					105 Stockton, Maryland																			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																		
First Middle Last					First Middle Last																																		
James M. Hoskins					Columbia					J. Herndon																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT										Address																			
Yes, na, or unknown					216-09-5926D					Md. Odd Fellows Home, Frederick, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 1. DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) Cerebral vascular accident															2 weeks																								
437.9 DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																							
(b) Cerebral arteriosclerotic vascular disease															5 years																								
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
					HOUR A.M. Month Day Year																																		
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>																																							
22a. I certify that (I) (this hospital) attended the deceased from July, 1965, to March 30, 1969, that (I) (we) last saw the deceased alive on March 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE															22c. DATE SIGNED																								
Le Roy T. Davis																																							
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS																								
Dr. LeRoy T. Davis M.D.															228 North Market Street, Frederick, Md.																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																								
Burial					April 2, 1969					Parsons Cemetery					Salisbury, Wicomico, Md.																								
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE														
M. R. Etchison & Son 106 E. Church St. Fred., Md.															APR 2 1969										Charles Judge														

03802

03801

GENERAL REPORT

DATE: 11/11/54 TIME: 10:00 AM

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph report or memorandum.]



03869

## CERTIFICATE OF DEATH

03862

1. DECEASED-NAME (Type or print) <b>Carrie May Easterday</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1969</b>			2b. HOUR <b>4 a. M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>February 14, 1892</b>		6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Route 4</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 4</b>	
14. FATHER'S NAME First Middle Last <b>Daniel Michael Whipp</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Jane Myers</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217 32 7273 F2</b>		17. INFORMANT Address <b>Donald G. Easterday, Rt. 4, Frederick, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Venous</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/10, 1969</b> , to <b>3/25, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/24, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert S. Hughes</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>March 25, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Robert S. Hughes, M. D.</b>				22e. ADDRESS <b>700 Montclair Ave, Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 27, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Feagaville Frederick Md.</b>			
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>				25a. REC'D BY REGISTRAR <b>D MAR 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Indle</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03883

CERTIFICATE OF MARRIAGE

THE STATE OF CALIFORNIA, COUNTY OF LOS ANGELES, SOLEmnly proclaims that

On the 11th day of June, 1964, at the County of Los Angeles, State of California, I, the undersigned, a duly authorized Minister of the Gospel, did solemnize the marriage of

Mr. and Mrs. [illegible] and [illegible]

and did certify that the same was lawfully contracted according to the rites and ceremonies of the [illegible] and the laws of the State of California.

Witness my hand and the seal of my office this 11th day of June, 1964, at the County of Los Angeles, State of California.

[illegible signature]

[illegible signature]

[illegible signature]

[illegible signature]

[illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03870		CERTIFICATE OF DEATH						03863					
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
MINNIE			T.		FLEMING				March		Day 22 Year 1969 10:50		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years day birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		July 24, 1888				80 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			U. S. A.						Frederick Md.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick				Monocacy Hall Nursing Home				Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Carroll		Westminster		YES		112 Anchor Street			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
Edward			F.		Tucker, Sr.				Sallie			Mull	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			Westminster, Md.	
No			214 10 2977 A			Mrs. C. Edward Cootes, 112 Anchor St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic pyelonephritis &amp; cerebral thrombosis</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>22 Mar</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>21 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>James E. Stoner, Jr.</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. PHYS.								22c. DATE SIGNED March 24, 1969					
22d. PHYSICIAN'S NAME (Type) James E. Stoner, Jr. M.D.								22e. ADDRESS Walkersville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			March 25, 1969		Mount Olivet Cemetery			Frederick Frederick Md.					
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland						25a. REC'D BY REGISTRAR DATE MAR 26 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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STATE OF TEXAS

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03864						
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or Print)			First John			Middle Wm.			Last Flickinger			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 17 1969		2b. HOUR 11:45 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Apr. 28-1921		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 3 Day 17 Year 1969		2d. HOUR 7:30 P.M.		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Frederick				Md.			
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 105 W. 14th. St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter- Auto Shop			12b. KIND OF BUSINESS OR INDUSTRY Re. Garage							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Frederick			13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 105 W. 14th. St.					
14. FATHER'S NAME First Wm. Middle Henry Last Flickinger			15. MOTHER'S MAIDEN NAME First Ruth Middle N. Last Boone													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			(If yes give war or dates of service) W War II			16b. SOCIAL SECURITY NO. 217-16-2213			17. INFORMANT 105 W. 14th. St. ADDRESS Frederick-Md. Mrs. Evelyn Clabaugh Flickinger-							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																
ACTUAL SIGNATURE <u>Robert J. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 3-17-69								
EXAMINER'S NAME (Type) Robert J. Thomas				ADDRESS (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Mar. 20-1969		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens				23d. LOCATION (City or Town) (County) (State) N. of Frederick, Md. 21701						
24. FUNERAL DIRECTOR M.R. Etchison & Son				ADDRESS Frederick, Md. 21701				25a. REC'D BY REGISTRAR DATE MAR 21 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03872

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03865

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Olive Wesley Ford</b>			2a. DATE OF DEATH <b>3</b> Month <b>5</b> Day <b>69</b> Year			2b. HOUR <b>7:45a</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>November 25, 1892</b>		6. AGE (In years lost birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Md. I.O.O.F.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3408 Chestnut Avenue</b>	
14. FATHER'S NAME First <b>Robert</b> Middle <b>J.</b> Last <b>Ford</b>			15. MOTHER'S MAIDEN NAME First <b>Johanna</b> Middle <b>C.</b> Last <b>Ford</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>217-01-9816 A</b>		17. INFORMANT Address <b>Md. Odd Fellows Home, Frederick, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>3 years.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>68</b> , to <b>March 3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased olive on <b>March 3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Le Roy T. Davis</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>March 5, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Le Roy Davis M. D.</b>				22e. ADDRESS <b>228 North Market Street, Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 7, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Balt. Md.</b>			
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

08879

Olive      Mary      Ford      2      59      7:45

Female      White      November 22, 1903      75

Maryland      H.      Frederick

Frederick      Md. L. A. P.      Married Secretary

Maryland      Baltimore Baltimore      x      2400 Chestnut Avenue

Robert      J.      Ford      Johann      C.      Ford

215-01-0818 A      Md. 600 Pollock Home, Frederick, Md.

225 North Market Street, Frederick, Md.

Frederick, Md.      Baltimore, Md.      1000 Baltimore Cemetery      March 1, 1900      1000 Baltimore Cemetery      March 1, 1900      1000 Baltimore Cemetery      March 1, 1900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03873

03866

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH				2b. HOUR				
Gaither R. Kr			FRUSHOUR			Month Day Year 3 28 1969				M				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD				2d. HOUR		
male	caus.	June 4, 1928	40 YRS.					Month Day Year March 28 1969				M		
70. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				Md.	
Fred. Co. Md.			U.S.A.						Frederick					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Myersville			Route # 2			Carpenter			Construction					
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Frederick			Myersville			Route # 2					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last								
Ralph B. Frushour			Erma Elizabeth Gaver											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			229-34-5429			Mrs. Margaret L. Frushour			Myersville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8129 FRACTURED SKULL</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5 3-28 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) TWO CAR - HEADON - COLLISION								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HIGHWAY			21f. LOCATION Street or R.F.D. No. City or Town County State MYERSVILLE - FREDERICK - MD.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Robert J. Thomas			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 29 MAR 69					
EXAMINER'S NAME (Type)			Robert J. Thomas			ADDRESS (Street, city, town, or county)								
230. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Mar. 31, 1969			Mt. Zion U. Methodist			Myersville, Fred. Co. Md.					
24. FUNERAL DIRECTOR			ADDRESS			250. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Paul R. Bitter			Myersville, Md.			DATE APR 2 1969			J. Charles Judge					

0330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03867

03874

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Joseph Francis Geiselman			2a. DATE OF DEATH Month Day Year March 17, 1969			2b. HOUR 1:30 PM									
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 19, 1912		6. AGE (In years lost birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.									
10. CITY OR TOWN OF DEATH Emmitsburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D.# 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Emmitsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D.# 1							
14. FATHER'S NAME First Middle Last Charles E. Geiselman Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Marie McNulety			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes			16b. SOCIAL SECURITY NO. WW 2			17. INFORMANT Address 21727 Charles E. Geiselman, Emmitsburg, Md. R.D.# 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uncontrolled Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>March 17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>W R Cadle</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>March 17 1969</u>	
22d. PHYSICIAN'S NAME (Type) Dr. W. R. Cadle				22e. ADDRESS Emmitsburg, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 20, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Anthony's Shrine		23d. LOCATION (City or Town) (County) (State) Emmitsburg, Frederick Co. Md.		25a. RECEIVED BY REGISTRAR MAP 19 1969				25b. REGISTRAR'S SIGNATURE <u>W R Cadle</u>			
24. FUNERAL DIRECTOR <u>Clarence E. Wilson</u>				ADDRESS Emmitsburg, Md.				DATE							

03276



# FOR STATE HEALTH DEPT.

03875

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03868

1. DECEASED-NAME (Type or Print)		First <b>LEVI</b>		Middle <b>T.</b>		Last <b>GRAY</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>3</b> Day <b>26</b> Year <b>1969</b>			2b. HOUR <b>5 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Aug. 24, 1906</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>3</b> Day <b>26</b> Year <b>1969</b>		2d. HOUR <b>5 P.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>						
10. CITY OR TOWN OF DEATH <b>Rural-Mt. Airy</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 4</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Warehouseman</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 4</b>		
14. FATHER'S NAME First <b>Tildon</b> Middle <b>H.</b> Last <b>Gray</b>				15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Aleshire</b> Last <b>Aleshire</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW 2</b>		17. INFORMANT <b>6211 44th Ave. Clarence W. Gray Riverdale, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Robert J. Thomas</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>3/27/69</b>				
EXAMINER'S NAME (Type) <b>Robert J. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS <b>C. M. Waltz, Box 241, Sykesville, Md.</b>				ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/29/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove</b>				23d. LOCATION (City or Town) (County) (State) <b>Frederick, Md.</b>				
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>						25a. REC'D BY REGISTRAR <b>APR 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MEDICAL CERTIFICATION

03875

Robert J. Thomas, A.U.

CERTIFICATE OF DEATH

03869

1. DECEASED NAME (Type or print) <b>RUSSELL LAFAYETTE GRIMES</b>			2a. DATE OF DEATH <b>March 14 1969</b>			2b. HOUR <b>7:45 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JAN 1 1898</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>FREDERICK</b> Md.			
10. CITY OR TOWN OF DEATH <b>WALKERSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GOLDSBORO PLACE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SHIPPING (RECK-CEMENT)</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) <b>MARYLAND</b> STATE <b>FREDERICK</b> COUNTY <b>WALKERSVILLE</b>		13b. CITY OR TOWN <b>WALKERSVILLE</b>		13c. IN OR CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET AND NUMBER <b>GOLDSBORO PLACE</b>			
14. FATHER'S NAME First Middle Last <b>JOHN GRIMES</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LAURA FISHER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or date of service)		16b. SOCIAL SECURITY NO. <b>MTI-05-7793</b>		17. INFORMANT Address <b>Mrs. F. E. SOFINOWSKI, WALKERSVILLE, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>1701</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignancy lower right mandible</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Jan. 1968</b> <b>Nov. 1968</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 10, 1969</b> , to <b>March 14, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 14 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>E. A. Dettbarn, M.D.</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/15/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>E. A. DETTBARN</b>				22e. ADDRESS <b>WALKERSVILLE, MD. 21713</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3/17/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEM.</b>		23d. LOCATION (City or town) (County) (State) <b>UNION BRIDGE, MD.</b>			
24. FUNERAL DIRECTOR <b>D. D. HARTZLER &amp; SONS</b>		ADDRESS <b>UNION BRIDGE</b>		25a. REC'D BY REGISTRAR <b>APR 19 1969</b>		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03877		CERTIFICATE OF DEATH								03870	
1. DECEASED-NAME (Type or print) First Middle Last NELLIE VICTORIA Grove				2a. DATE OF DEATH Month Day Year March 3, 1969				2b. HOUR 1:40 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Nov. 19, 1876		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick, Md.					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 143 West Patrick Street			
14. FATHER'S NAME First Middle Last Luther C. Derr				15. MOTHER'S MAIDEN NAME First Middle Last Victoria Fraley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 219-54-6905		17. INFORMANT Address Mr. Benjamin F. Grove, Jr. 143 W. Pat. St. Fred. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive failure of heart</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1968</u> , to <u>3/3, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James B. Thomas, M.D.</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED March 3, 1969			
22d. PHYSICIAN'S NAME (Type) Dr. James B. Thomas, M.D.				22e. ADDRESS 228 N. Market Street Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-6-1969		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Md.			
24. FUNERAL DIRECTOR <u>Robert E. Dailey &amp; Son</u> ADDRESS Frederick, Maryland				25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>					

08873

DEPARTMENT OF HEALTH

OFFICE OF THE ATTORNEY GENERAL

08873

RECEIVED  
DEPARTMENT OF HEALTH  
OFFICE OF THE ATTORNEY GENERAL  
JAN 10 1964



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03878

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03871

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Donald Wayne Grumbine</b>		First Middle Last		2a. DATE OF DEATH <b>March 15 Day 69 Year</b>		2b. HOUR <b>10:45 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 13-1941</b>		6. AGE (In years last birthday) <b>27</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Handicapped-Blind</b>		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <b>Wm. E. Grumbine</b>		First Middle Last		15. MOTHER'S MAIDEN NAME <b>Ruth V. Dudrow</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-40-3910</b>		17. INFORMANT <b>Mrs. Shirley G. Gross-1601-18th St. N.W.-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>2509</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Nephritis</b> (c) <b>Diabetes mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2 years</b> <b>23 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> , 19 <b>69</b> , to <b>3/15</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>3/15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James B. Thomas</b>		DEGREE <b>James B. Thomas</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Mar. 15-1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>James B. Thomas</b>		22e. ADDRESS <b>Prof. Bldg.-Frederick-Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 18-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodsboro- Md. 21798</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>		ADDRESS <b>Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>MAR 18 1969</b>		25b. REGISTRAR'S SIGNATURE <b>W. Charles Under</b>	

07850

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
11337										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
baby girl Hardy						Month 3 Day 21 Year 69		3:30p M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
female		white		3/21/69		YRS.		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Frederick				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Frederick			Frederick Memorial					---		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Frederick		Frederick		YES		Park Place	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Thomas Clifton Hardy			Gay Diane Hawkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			none		mother 123 Stewart Manor Apts, Fred, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anencephaly, <del>meningo</del> meningo myelocoele</u> 740x DUE TO, OR AS A CONSEQUENCE OF (b) <u>fetal anomaly incompatible with life</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>premature birth (2#12oz.)</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
---		---			YES		---			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. --- 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>69</u> , to <u>3/21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>30 min.</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Harry W. Gray</u> MD DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/21/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Harry W. Gray, M. D.</u>					22e. ADDRESS <u>Frederick, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		3/23/69		St. Mark's Cemetery, Petersville, Fred, Co., Md.						
24. FUNERAL DIRECTOR ADDRESS					25. DATE		25b. REGISTERED SIGNATURE			
Feete Funeral Home Brunswick, Md.					AUG 15 1969		<u>[Signature]</u>			

STATEMENT OF DEATH

1900

John Doe, of the County of ... State of ...  
do hereby certify that on the ... day of ...  
at ... in the County of ... State of ...  
the following named person died:  
Name: ...  
Age: ...  
Sex: ...  
Race: ...  
Cause of Death: ...  
Signature: ...  
Witness: ...

Signature of Doctor (M.D.)

Witnessed by me, the undersigned, a Justice of the Peace,  
on this ... day of ... 1900.  
Signature of Justice of the Peace  
Notary Public for the State of ...  
Signature of ...  
Signature of ...

03879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03872

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) <b>John Floyd Harp</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>3 28 1969</b>			2b. HOUR <input type="checkbox"/> <b>M</b>			
3. SEX <b>male</b>	4. RACE <b>caus.</b>	5. DATE OF BIRTH <b>Apr. 18, 1931</b>	6. AGE (In years last birthday) <b>37</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>March</b> Day <b>28</b> Year <b>1969</b>			
7a. BIRTHPLACE (State or foreign country) <b>Fred. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			
10. CITY OR TOWN OF DEATH <b>Myersville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route # 2</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Welder Trainee</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Todd Steel</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to State) <b>Maryland</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Myersville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME <b>John Franklin Harp</b>			15. MOTHER'S MAIDEN NAME <b>Leona E Cross</b>			13e. STREET AND NUMBER <b>Route # 2</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>Aug. 11, 1954 220-30-9385</b>		17. INFORMANT <b>Mrs. Leona E. Harp, Myersville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBDURAL HEMORRHAGE &amp; FRACTURED SKULL</b> <b>8129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>5 P.M. 3-28-1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <b>TWO CAR, HEAD-ON COLLISION</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>HIGHWAY</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>MYERSVILLE-FREDERICK-MD.</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Noturol causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Robert J. Thomas</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>MAR. 29, 1969</b>			
EXAMINER'S NAME (Type) <b>Robert J. Thomas</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <b>Myersville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 31, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion U. Methodist</b>			23d. LOCATION (City or Town) (County) (State) <b>Myersville, Fred. Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Paul F. Bittle, Myersville, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03880		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03873			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First Middle Last Elias Milo Hooper-Sr.						Mar. Month 19 Day 69 Year		10:10	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Feb. 7-1898		71 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Frederick Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Mem. Hospital		Farmer-Live Stock Dealer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Frederick		Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 10	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last James O. Hooper		First Middle Last Lillie May Stottlemeyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		None		Mrs. Ruth M. Hooper-Route 10-Frederick-Md.		21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/19/69, 19, to 3/19/69, 19, that (I) (we) last saw the deceased alive on 3/19/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Dr. A.A. Pearre-Jr.		Mar. 20-1969							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Dr. A.A. Pearre-Jr.		804 Toll House Ave., Frederick, Md. 21701							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 22-1969		Pleasant Hill Cemetery		Nr. Yellow Springs, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
M. R. Etchison & Son		Frederick, Md.		Mar 24 1969					

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## CERTIFICATE OF DEATH

03874

1. DECEASED-NAME (Type or print) <b>John Russell Huff</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>1969</b>			2b. HOUR <b>7:54</b> A M			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Dec. 9, 1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Fredrick</b>			
10. CITY OR TOWN OF DEATH <b>Mountairdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>-</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Fort Detrick</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Fredrick</b>		13c. CITY OR TOWN <b>Mountairdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>-</b>	
14. FATHER'S NAME First Middle Last <b>William Huff</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Aunie Mackley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-03-5216A</b>		17. INFORMANT Address <b>Mrs. Eleanor Y. Huff, Thurmont, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of esophagus</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>-</b>									
19a. DATE OF OPERATION <b>1965</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>prostate enlargement</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>8/5, 1968</b> to <b>3/10, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/7, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert H. Pilgram MD</b>					22c. DATE SIGNED <b>3/10/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Robert H. Pilgram</b>					22e. ADDRESS <b>Pro 5. Bldg. Frederick, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/13/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Fred. Md</b>			
24. FUNERAL DIRECTOR <b>J.C. Barten, Walkersville, Md. 21793</b>				25a. REC'D BY REGISTRAR <b>MAR 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03882

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03875

1. DECEASED-NAME (Type or Print) <b>ADAM</b>			First Middle Last <b>James</b>			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 3-15-1969			2b. HOUR <b>8:30</b> M				
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH <b>7/15/1910</b>	6. AGE (in years last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <b>19</b>			2d. HOUR M				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			Md.				
10. CITY OR TOWN OF DEATH <b>Petersville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Petersville</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
14. FATHER'S NAME <b>Charles</b>			First Middle Last <b>James</b>			15. MOTHER'S MAIDEN NAME <b>Fannie</b>			First Middle Last <b>Price</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>230-18-3084</b>			17. INFORMANT ADDRESS <b>Mrs. Julia James-Knoxville, Md. R.F.D. I</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> 8147 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>FRACTURED SKULL &amp; LAC. BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>7:55</b> P.M. <b>3-15-1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <b>HIT BY MOTOR VEHICLE</b>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HIGHWAY</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>RTE 180 - PETERSVILLE - FREDERICK - MD.</b>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Robert J. Thomas</b>			EXAMINER'S NAME (Type) <b>Robert J. Thomas M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>16 MAR 69</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/19/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Petersville Fred. Md.</b>					
24. FUNERAL DIRECTOR <b>Feete Funeral Home</b>					ADDRESS <b>Brunswick, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 18 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>18-22a Film 411</div> <div>1-8-69 ams</div> <div>03883</div> <div>03876</div> </div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Deanne Carol Jenkins						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> 3 27 1969			p M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female	Negro	10-21-1968	YRS. 5	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Frederick Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Frederick			131 W. South Street			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md			Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		131 W. South Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Charles Lee Jenkins			D'Jaris Eileen Henderson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			None		Charles L. Jenkins 131 W. South Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive heart failure									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Acute bronchitis, pneumococcal & S.Aureus									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Endocardial fibroelastosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			27 MAR 69			
Robert J. Thomas			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
			Frederick, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		3-29-1969		St. Peters Catholic		Libertytown Fred. Md			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C.E. Hicks, 111 263 W. Patrick St, Fred. Md					DATE APR 1 1969		Charles Judge		

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64. In 1998, the U.S. Census Bureau reported that 1.5% of the U.S. population was 65 years of age or older.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03884

03877

1. DECEASED-NAME (Type or print) <i>Oscar</i>			First Middle Last <i>Joy</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1969</i>			2b. HOUR <i>8:00 A.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>JULY 12 - 1894</i>			6. AGE (In years last birthday) <i>74</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>FREDERICK</i>					
10. CITY OR TOWN OF DEATH <i>FREDERICK</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL HOSPITAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>CARPENTER &amp; PAINTER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>REPAIR</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>FREDERICK</i>			13c. CITY OR TOWN <i>LIBERTYTOWN</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>NONE</i>	
14. FATHER'S NAME First Middle Last <i>CHARLES E JOY</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>MARY CATHERINE HARP</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>212-24-6495</i>		17. INFORMANT Address <i>GENEVIEVE JOY LIBERTYTOWN MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>4319</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arterio-sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>10 years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arterio-sclerotic C.V. Diseases</i> <i>10 years</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1</i> , 19 <i>55</i> , to <i>March 25</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>March 24</i> , 19 <i>69</i> , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bernard O. Thomas Jr.</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>March 25, 1969</i>		
22d. PHYSICIAN'S NAME (Type) <i>Bernard O. Thomas Jr.</i>			22e. ADDRESS <i>Fredrick, Md 21701</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3/28/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FAIRMOUNT</i>			23d. LOCATION (City or Town) (County) (State) <i>LIBERTYTOWN MD</i>				
24. FUNERAL DIRECTOR <i>D.D. Hartley &amp; Sons Libertytown</i>						25a. REC'D BY REGISTRAR <i>MAR 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

3880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

03885

CERTIFICATE OF DEATH

03878

1. DECEASED-NAME (Type or print) <b>MARGARET ELIZABETH KEENEY</b>			20. DATE OF DEATH <b>3</b> Month <b>26</b> Day <b>1969</b> Year			2b. HOUR <b>5 A M</b>			
3. SEX <b>F</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>4/10/1890</b>		6. AGE (In years last birthday) <b>78</b> YRS. <b>#</b> MONTHS <b>#</b> DAYS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>FREDERICK</b> Md.			
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FREDERICK HOSPITAL CONV. CENTER</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>MIDDLEBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>NONE</b>	
14. FATHER'S NAME First Middle Last <b>SAMUEL SMITH</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>CLARA ZECH</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>MARGARET MAIN UNION BRIDGE MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>proctitis</b> <b>1 1/2 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mths</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>recto - vaginal fistula,</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/24</b> , 19 <b>68</b> , to <b>3/26</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/26</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frank Damm</b>		22c. DATE SIGNED <b>3/26/69</b>		22d. PHYSICIAN'S NAME (Type) <b>FRANK DAMM MD</b>		22e. ADDRESS <b>700 Montclair Ave Fred. Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAR 29-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEAVER DAM</b>		23d. LOCATION (City or Town) (County) (State) <b>UNION BRIDGE RURAL MD</b>			
24. FUNERAL DIRECTOR <b>D. Hart</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



03882

CRIMINAL RECORDS

03882

RECEIVED  
JAN 10 1964  
FBI - NEW YORK

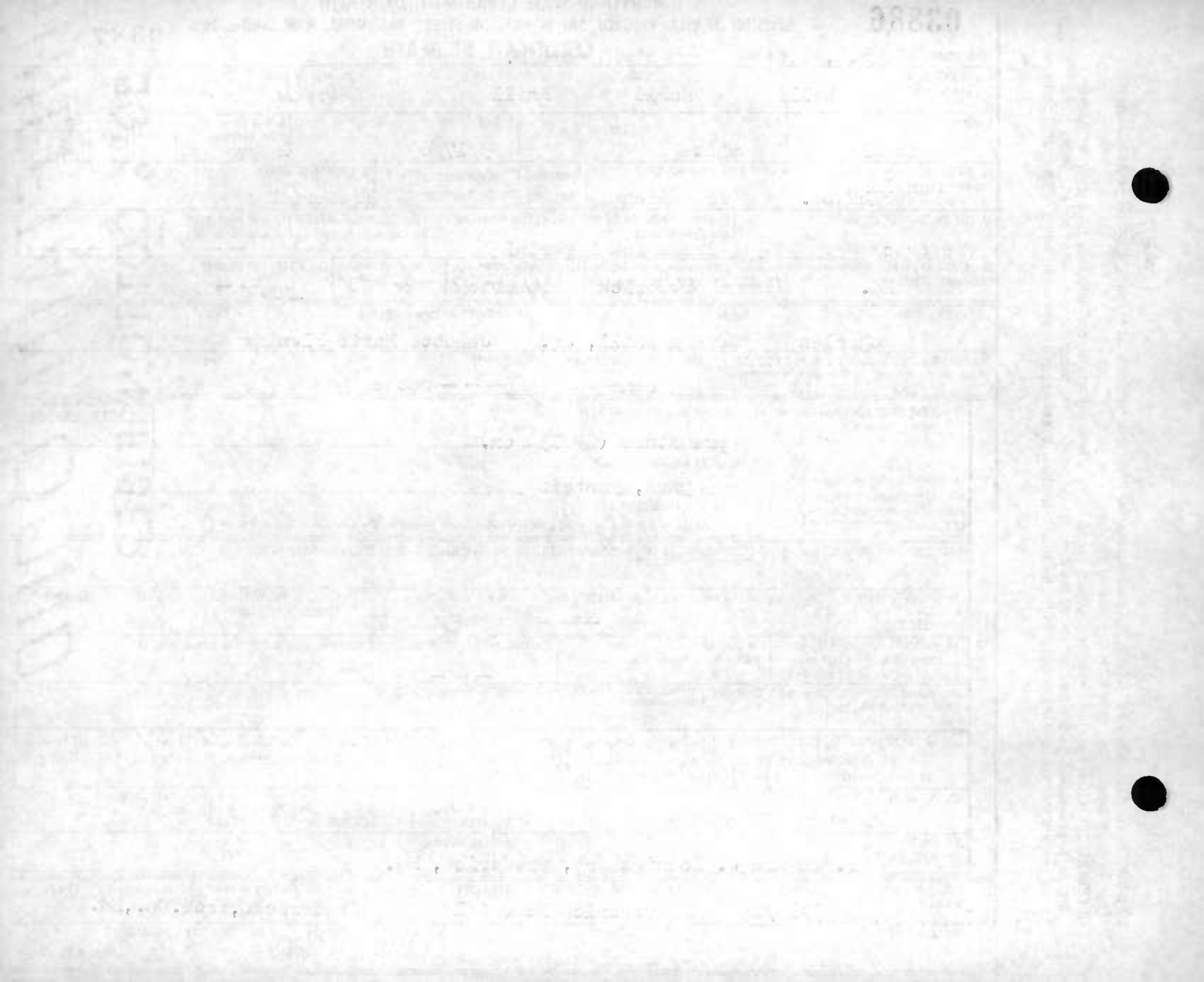


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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Kelli Marie Knill						March 18 Day 1969		7:45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
female		white		3/17/69		2 day YRS.		1 19		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland Frederick Co.		Frederick				Frederick		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Frederick			Frederick Memorial							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Howard		Frederick		YES		Route # 2	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Charles Gordon Knill, Jr.			Janette Marie Fleming							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
no		none		--- mother						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) premature (2# 13 1/2 oz.)										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) apnea, cyanosis										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Probably hyaline membrane disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1969, to March 18, 1969, that (I) (we) last saw the deceased alive on March 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward J. Koenigsberg					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/18/69			
22d. PHYSICIAN'S NAME (Type) Dr. Edward J. Koenigsberg, Frederick, Md.					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Release hospital		3/18/69		Frederick Memorial		Frederick, Md.				
24. FUNERAL DIRECTOR Charles A. Markel, Adam Frederick Memorial Home					25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13  
45M

03887		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03880	
1. DECEASED-NAME (Type or print) <b>Thurston</b>		First <b>Theodore</b>		Middle <b>Lincks</b>	
3. SEX <b>m</b>		4. RACE <b>w</b>		5. DATE OF BIRTH <b>4/16/1911</b>	
7a. BIRTHPLACE (State or foreign) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Trackman-B&amp;O R.R.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Knoxville</b>	
14. FATHER'S NAME First <b>Lewis</b>		Middle <b>Henry</b>		Last <b>Lincks</b>	
15. MOTHER'S MAIDEN NAME First <b>Lovetta</b>		Middle <b>Viola</b>		Last <b>Cooper</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-09-8290</b>		17. INFORMANT <b>Mrs. Hilda Stella Lincks-Knoxville,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>153.8</b> IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the colon &amp; carcinoma of the</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease &amp; myocardial ischemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>4 Feb 69</b> , 19 <b>69</b> , to <b>15 Mar</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>15 Mar</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>George I. Smith</b>		22c. DATE SIGNED <b>15 Mar 69</b>	
22d. PHYSICIAN'S NAME (Type) <b>George I. Smith, Jr. M.D.</b>		22e. ADDRESS <b>804 Toll House Ave. Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/18/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights Cemetery</b>	
23d. LOCATION (City or Town) <b>Brunswick, Md.</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>Feete Funeral Home-Brunswick, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 18 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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Thompson

Theodore

4/16/1911

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U. A.

Knoxville

Knoxville

Knoxville

Knoxville

Knoxville

Knoxville

Knoxville

Knoxville

George I. Smith, Jr. D.D. 801 Hill House Ave. Frederick, Md.

Burial 3/15/00 Park Heights Cemetery Annapolis, Md.

Reste Funeral Home-Annapolis, Md.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03888

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03881

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b. HOUR	
Ralph			Thurston			Lyles				March 25 1969 4p M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR				
Male	Negro	10-22-1920	48 YRS.		March 25 1969		4p M				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.			Frederick			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Iiamsville			Bethesda Rd Rtl			Plumbers Helper					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md			Frederick			Iiamsville			Bethesda Rd, Rt 1		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Clarence Henry Lyles			Ella May Virginia Lyles								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			*****			214-12-7943 Russell Lyles Hyattstown Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) COR PULMONALE DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Robert J. Thomas				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 26 MAR 69			
EXAMINER'S NAME (Type) Robert J. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county) Frederick, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-29-1969			Fairview			Frederick Fred. Md		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
C.E. Hicks, 111 Frederick, Md						APR 1 1969			Charles Judge		

82880

100-443887-100

U.S. DEPARTMENT OF AGRICULTURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
03889 CERTIFICATE OF DEATH 03882												
1. DECEASED-NAME (Type or print) First Middle Last JOSEPH ALLEN McABEE						2a. DATE OF DEATH Month Day Year March 07 1969			2b. TIME OF DEATH 12:30 PM			
3. SEX Male			4. RACE White			5. DATE OF BIRTH March 6, 1905			6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Frederick Md.			
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Limekiln, Maryland	
14. FATHER'S NAME First Middle Last Joseph Franklin McAbee						15. MOTHER'S MAIDEN NAME First Middle Last Eliza Funk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Yes						16b. SOCIAL SECURITY NO. 217 05 4476		17. INFORMANT Mrs. A. K. Leon, 326 Lindbergh Ave. Address Frederick, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pulmonary Emphysema</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>6 mos(?)</u> <u>10 yrs (+)</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 1968, to <u>7 March</u> , 1969, that (I) (we) last saw the deceased alive on <u>7 March</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Charles H. Conley, Jr. M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7 March 1969</u>		
22d. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr. M.D.						22e. ADDRESS 228 N. Market Street, Frederick, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Hospital			23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md.				
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>						25a. REC'D BY REGISTRAR <u>11 MAR 11 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

08880

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DIAGNOSIS: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

DATE: [illegible]

PLACE: [illegible]

STATE: [illegible]

CITY: [illegible]

COUNTY: [illegible]

ZIP CODE: [illegible]

REGISTRATION NO.: [illegible]

FILE NO.: [illegible]

DATE OF FILING: [illegible]

PLACE OF FILING: [illegible]

STATE OF [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <b>Robert Hunter McAfee</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> 3 10 1969		2b. HOUR <input type="checkbox"/> M	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>5-12-1910</b>		6. AGE (In years last birthday) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <b>March 10</b> 1969		2d. HOUR <input type="checkbox"/> M	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Frederick</b>			Md.	
10. CITY OR TOWN OF DEATH <b>Thurmont</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Lantz</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>rural</b>			
14. FATHER'S NAME First Middle Last <b>Ruban McAfee</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosa P. Lewis</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-14-6570</b>		17. INFORMANT <b>Nora McAfee Lantz, Md.</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Environmental exposure - Freezing</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute alcoholism</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Robert J. Thomas</b> EXAMINER'S NAME (Type) <b>Robert J. Thomas</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>10 MAR 69</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>3-12-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Methodist Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Garfield Fred. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>						ADDRESS <b>Thurmont, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>W. Charles Judge</b>	

10734-15-5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

03891										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03884																													
Item 5 Film 411 4/2/69 kk										CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or print) First Middle Last <b>Sarah Tiller Miller</b>										2a. DATE OF DEATH Month Day Year <b>3 22 69</b>										2b. HOUR MIN <b>11:10</b>																													
3. SEX <b>female</b>										4. RACE <b>caucasian</b>										5. DATE OF BIRTH <b>10/16/72 1882</b>										6. AGE (In years last birthday) YRS. MONTHS DAYS <b>86 5 6</b>																			
7a. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>										7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <b>Frederick</b>																			
10. CITY OR TOWN OF DEATH <b>Frederick</b>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>										13b. COUNTY <b>Frederick</b>										13c. CITY OR TOWN <b>Frederick</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <b>104 North Bentz Street</b>									
14. FATHER'S NAME First Middle Last <b>Beverly Welford Brown</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Virginia Walter</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>										16b. SOCIAL SECURITY NO. <b>219 54 0693 J</b>										17. INFORMANT Address <b>Wilbur F. Miller, 104 N. Bentz St. Frederick, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1519</b> IMMEDIATE CAUSE (a) <b>Adenocarcinoma Stomach</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <b>6-7</b> , 19 <b>65</b> , to <b>3-22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-22</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <b>Thomas E. Stone</b>										22c. DATE SIGNED <b>March 24, 1969</b>																													
22d. PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M.D.</b>										22e. ADDRESS <b>4 W. Third Street, Frederick, Maryland</b>																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE <b>March 24, 1969</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>										23d. LOCATION (City or Town) (County) (State) <b>Frederick, Frederick Md.</b>																			
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>										ADDRESS <b>Frederick</b>										25a. REC'D BY REGISTRAR <b>MAR 26 1969</b>										25b. REGISTRAR'S SIGNATURE <b>James Judge</b>																			

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Frederick

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Procedural Innovation in the North American States

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03892

CERTIFICATE OF DEATH

03885

1. DECEASED-NAME (Type or print) First Middle Last Lillie Elizabeth Mullinix			2a. DATE OF DEATH Month Day Year March 10 1969		2b. HOUR 1:pm			
3. SEX Female	4. RACE White		5. DATE OF BIRTH August 20, 1885		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.		
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 920 N. Market Street
14. FATHER'S NAME First Middle Last John Matthew Spaulding			15. MOTHER'S MAIDEN NAME First Middle Last Mary Becraft					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. -1 (If yes give war or dates of service) 220 44 8258		17. INFORMANT Address Mrs. Richard F. Kline, Frederick, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Recent coronary</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 69, to March 10 19 69, that (I) (we) last saw the deceased alive on March 10 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. Austin Pearre, Jr.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 11, 1969		
22d. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr.				22e. ADDRESS Toll House Ave, Frederick, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 12, 1969		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth. Cemetery		23d. LOCATION (City or Town) (County) (State) Damascus Montgomery Md.		
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md.				25a. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE		

COLLECTION

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03880

EXHIBIT OF DATA

03882

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
45M - 19 69

03893		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03886	
Item 6 Film 410 3/20/69 kk					
1. DECEASED-NAME (Type or print) <b>David Emory Nelson</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>1969</b> 2b. HOUR <b>6:35</b> P.M.		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>7/8/1890</b>	
6. AGE (In years or birthday) <b>79</b> YRS.		7. AGE (In years or birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Frederick</b>		Md.			
10. CITY OR TOWN OF DEATH <b>Knoxville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Residence</b>		12a. USUAL OCCUPATION (Kind of work done during life) <b>Retired Trainman</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Knoxville</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First <b>James</b> Middle <b>Emory</b> Last <b>Nelson</b>			15. MOTHER'S MAIDEN NAME First <b>Hannah</b> Middle <b>Holmes</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>705-05-7942</b>		17. INFORMANT Address <b>Mrs. Martha E. Nelson, Knoxville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 year</b> <b>10 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 5, 1962</b> to <b>Mar. 14, 1969</b> , that (I) (we) last saw the deceased alive on <b>Mar. 14, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. T. Byron Kao, M.D.</b>		22c. DATE SIGNED <b>Mar. 15, 1969</b>		22d. PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M.D.</b>	
22e. ADDRESS <b>Gum Spring Hollow Brunswick, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3/18/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Petersville Fred. Md.</b>					
24. FUNERAL DIRECTOR <b>Feete Funeral Home-</b>		ADDRESS <b>Brunswick, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 18 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

03822

David Army Nelson

White

1/1/1880

Kentland

U.S.A.

Kentland

Knoxville

Kentland

Kentland-Kentland and U.S.

Kentland

Kentland

James

Kentland

Kentland

Kentland

no

James E. Nelson, Knoxville, Tenn.

1/1/1880

1/1/1880

1/1/1880

Kentland-Kentland and U.S.

Kentland-Kentland and U.S.

1/1/1880

Kentland-Kentland and U.S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03894		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		03887	
1. DECEASED-NAME (Type or print) <b>EARL</b> First <b>CHARLES</b> Middle <b>NUSE</b> Last				2a. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>69</b>		2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>I/II/02</b>		6. AGE (In years (b) birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>Frederick Memorial</b>		12a. USUAL OCCUPATION (Kind of work done (b) (c) working before death) <b>Retired B.O. R.R.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Knoxville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Jacob</b> Middle <b>L.</b> Last <b>Nuse</b>		15. MOTHER'S MAIDEN NAME First <b>Ada</b> Middle <b>V.</b> Last <b>Ayers</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (b) (c) (If yes give war or dates of service) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>705-10-2739</b>		17. INFORMANT Address <b>Bettie J. Midgett-Knoxville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>203X Azoemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic nephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myeloma</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>?</b> <b>6 mos. ±</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>now</b> , 1968, to <b>5 March</b> , 1969, that (I) (we) last saw the deceased alive on <b>4 March</b> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles H. Conley, Jr. M.D.</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5 March 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>CHARLES H. CONLEY, JR</b>				22e. ADDRESS <b>FREDERICK, Md.</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/8/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brunswick Fred. Md.</b>	
24. FUNERAL DIRECTOR <b>Feete Funeral Home Brunswick, Md.</b> ADDRESS				25a. RECEIVED BY REGISTRAR <b>MAR 6 1969</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Walter L. Judge</b>	

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Volume 10, Number 1

07/01/2004

THE UNIVERSITY OF CHICAGO

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• 30 • November 2001



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>03895</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03888</div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
George Wilbur Osmun						Month Day Year		3 19 1969 4:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Oct. 29-1876		92 YRS.	MONTHS DAYS		Month Day Year		5:30 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U.S.A.				Frederick Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Frederick			1301 Motter Ave.			Retired Minister			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.			Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1301 Motter Ave.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John W. Osmun			Emma Cook						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			212-38-8622		Mrs. Sarah E. White Osmun- Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			M.D.			3-19-69			
Robert J. Thomas, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Mar. 22-1969		Mt. Olivet Cemetery		Frederick- Frederick-		Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
M.R. Etchison & Son			Frederick, Md. 21701			MAR 24 1969		J. Charles Judge	

00885

ROBERT J. THOMAS, JR.

1955

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03896

03889

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Rogers		L.		Roles	MARCH 29 1969		3	29	1969	2:15 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	3/14/1948		21 YRS.	MONTHS DAYS HOURS MIN.		Month 3 Day 29 Year 1969		2d. HOUR 2:15 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH
W. Va.		U.S.A.		WIDOWED		DIVORCED		Frederick		Frederick
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN
Frederick Mem. Hosp.		Carpenter		Building		Md.		Montg.		Rockville
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
John Earl Roles		Ruby Parker		Yes		51-663-428		John E. Roles		Same as item #13e.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATED BRAIN										immediate
DUE TO, OR AS A CONSEQUENCE OF (b) CRUSHED SKULL										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19		Auto Accident						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
		HIWAY		MT Airy		CAROL		MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Robert J. Thomas				M.D.		22b. DATE SIGNED		3-29-69
EXAMINER'S NAME (Type)		Robert J. Thomas				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		4/2/69		Baltimore National		Baltimore		Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tyson Wheeler Funeral Home				1331 Rockville Pike		DATE APR 7 1969		J. Charles Judge		
				Rockville, Md.						

03886

EDUCATIONAL & CULTURAL

03886

NAME	LAST	FIRST	MIDDLE	SUFFIX
JOHN	DAVID	JOHN		
DATE OF BIRTH	SEX	EDUCATION	RELIGION	ETHNICITY
1945	M	HS		
DATE OF DEATH	CAUSE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	DATE OF BURIAL
DATE OF INTERVIEW	INTERVIEWER	INTERVIEW LOCATION	INTERVIEW METHOD	INTERVIEW TYPE
DATE OF RECORDING	RECORDING METHOD	RECORDING LOCATION	RECORDING TYPE	RECORDING SOURCE
DATE OF ANALYSIS	ANALYSIS METHOD	ANALYSIS LOCATION	ANALYSIS TYPE	ANALYSIS SOURCE
DATE OF REPORTING	REPORTING METHOD	REPORTING LOCATION	REPORTING TYPE	REPORTING SOURCE
DATE OF REVIEW	REVIEW METHOD	REVIEW LOCATION	REVIEW TYPE	REVIEW SOURCE
DATE OF FINALIZATION	FINALIZATION METHOD	FINALIZATION LOCATION	FINALIZATION TYPE	FINALIZATION SOURCE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03897

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03890

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Arie Rebecca Routzahn						Month 3 Day 13 Year 1969			10:00 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Jan. 29-1892	77 YRS.	MONTHS	DAYS	HOURS	MIN.	Month 3 Day 13 Year 1969			11:10 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U. S. A.				Frederick Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick			DOA-Fred'k. Mem. Hospital			Housekeeper			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.			Frederick		Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 10		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Charles Henry Routzahn			Phebe Cramer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No			220-44-1053		Harry C. Routzahn-Route 10-Frederick-Md.21701						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Acute Gastric Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			R. J. Thomas, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			3-13-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Mar. 15-1969		Mt. Olivet Cemetery		Frederick-		Frederick-Md.		21701	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
M.R. Etchison & Son			Frederick, Md. 21701			MAR 17 1969					



72850

1992

3-13-01



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 411

4/2/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03891

1. DECEASED-NAME (Type or Print) <b>Clarence Preston Sampsell</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 24 1969			2b. HOUR 12 M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 15, 1921</b>	6. AGE (In years last birthday) <b>47 46</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3 Day 24 Year 1969		
7a. BIRTHPLACE (State or foreign country) <b>Bunker Hill, W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.		
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Warehouse Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. Supplies</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Frederick</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route # 8 Box 122</b>		
14. FATHER'S NAME First Middle Lost <b>John Albert Sampsell</b>			15. MOTHER'S MAIDEN NAME First Middle Lost <b>Lottie Mae Bowers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-12-2724</b>		17. INFORMANT ADDRESS <b>Mrs. C.P. Sampsell R #8 Box 122 Frederick, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Corruptive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Alcohol-induced Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Alcohol</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Robert J. Thomas</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>3-24-69</b>		
EXAMINER'S NAME (Type) <b>Robert J. Thomas, M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/27/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington-Md.</b>		
24. FUNERAL DIRECTOR <b>Wm. G. Host</b> <b>Rest Haven Funeral Chapel</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

ROBERT J. THOMAS, M.D.  
812 TOLL HOUSE AVENUE  
FREDERICK, MARYLAND

03898

1941-1942

017-12-0234

W.C. Hunt

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03899		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03892					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Carmen		Margaret		Simpson				March Month 3 Day 69 Year		11:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		May 9-1898		70		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.A.				Frederick					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Mem. Hospital		Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Frederick		Frederick				244 W. 5th. St.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
		Not available						Klipp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Frederick Address Md. 21701			
No				219-54-1046		Chas. W. Simpson-Jr.-202 Rockwell Terrace-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4109		DUE TO, OR AS A CONSEQUENCE OF		(b)		RECENT POST. MYOCARDIAL INFARCT					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c)		ARTERIOSCLEROTIC HEART DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Oct, 1968, to 3 MAR, 1969, that (I) (we) last saw the deceased alive on 3 MAR 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		George I. Smith, Jr.		22c. DATE SIGNED		3 MAR 69					
22d. PHYSICIAN'S NAME (Type)		George I. Smith, Jr.		22e. ADDRESS		804 Toll House Ave.-Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Mar. 6-1969		Mt. Olivet Cemetery		Frederick Frederick- Md.					
24. FUNERAL DIRECTOR		Elwood T. M.R. Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE MAR 10 1969		J Charles Judge			

02820

CERTIFICATE OF DEATH

02820

NAME: [illegible]

AGE: [illegible]

SEX: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

PROFESSION: [illegible]

DECEASED AT: [illegible]

CAUSE OF DEATH: [illegible]

DECEASED AT: [illegible]

CAUSE OF DEATH: [illegible]

DECEASED AT: [illegible]

CAUSE OF DEATH: [illegible]

DECEASED AT: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03900

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03893

1. DECEASED-NAME (Type or print) First Middle Last <b>Blanche S. Summers</b>			2a. DATE OF DEATH Month Day Year <b>March 26 1969</b>		2b. HOUR <b>8:55AM</b>
3. SEX <b>female</b>	4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>9/15/1917</b>		6. AGE (In years last birthday) <b>52</b>
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		9. COUNTY OF DEATH <b>Frederick</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Middletown</b>	
14. FATHER'S NAME First Middle Last <b>Ethan Alan Angle</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Pearl Householder Angle</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <b>no</b>		16b. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT Address <b>Vernon A. Summers, Rt. 1 Middletown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma Left Breast 2 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>174X</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>7/28/67</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Breast ca</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/24</b> , 19 <b>67</b> to <b>3/26</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/26/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Frank Damazo MD</b>		22c. DATE SIGNED <b>3/26/69</b>		22d. PHYSICIAN'S NAME (Type) <b>FRANK DAMAZO</b>	
22e. ADDRESS <b>700 Montclair Rd</b>		22f. ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>		22g. ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 29, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion U. Meth.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Myersville, Md. Fred. Co. Md.</b>		23e. BY REGISTRAR <b>1969</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Robert H. Wall, Editor

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>03901</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03894</div>									
1. DECEASED-NAME (Type or print) First Middle Last <b>Leona P. Tressler</b>					2a. DATE OF DEATH Month 5 Day 69 Year <b>March</b>			2b. HOUR <b>1:15 M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 13-1899</b>		6. AGE (In years lost birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.			
10. CITY OR TOWN OF DEATH <b>Braddock Heights</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Vindobona Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Jefferson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>Luther Mann</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Nora Trittapoe</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-40-3676A</b>		17. INFORMANT Address <b>Harold S. Virts-53 Winchester St.-Frederick-Md. 21701</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour - many years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypothyroidism, Anemia, Emphysema</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Jan. 1966, to March 1969, that (1) (we) lost sown the deceased alive on March 1 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W.J. Riddick</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Mar. 6-1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. J.R. Poirier - or W.J. Riddick</b>		22e. ADDRESS <b>Fred'k. Medical Center-Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 8-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lovettsville- Virginia</b>			
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>		ADDRESS <b>Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1. The first of the three main parts of the report is a description of the work done during the year. This part is divided into three sections: (a) a description of the work done during the year, (b) a description of the work done during the year, and (c) a description of the work done during the year.

2. The second part of the report is a description of the work done during the year. This part is divided into three sections: (a) a description of the work done during the year, (b) a description of the work done during the year, and (c) a description of the work done during the year.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
03902					CERTIFICATE OF DEATH					03895							
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR					
Gertrude			Anna		Troxell		3 Month 19 Day 69 Year 9 45 P.M.										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			White			Nov. 16, 1875			93 YRS.			MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Maryland			U.S.A.						Frederick								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Frederick			Frederick Memorial			Housewife											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
Md.			Frederick			Frederick			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.D.# 3					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
John			Moser						Elizabeth			Barton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address								
No			215-20-9291-F2			Harry Troxell, Thurmont, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										10 min.							
4124 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>Adams - Stokes Syndrome</u>		4 weeks					
										(c) <u>Artherosclerotic cardiovascular disease</u>		3 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1969</u> , to <u>March 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1969</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Le Roy T. Davis			3/19/69			Le Roy T. Davis			Frederick, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			March 23, 1969			Elias Lutheran Cemetery			Emmitsburg, Frederick Co. Md.								
24. FUNERAL DIRECTOR			25a. REGD. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			DATE								
Clarence E. Wilson			MAR 24 1969			MAR 24 1969											
Clarence E. Wilson			Emmitsburg, Md.														

10343

DEPARTMENT OF COMMERCE

03002

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Bureau of Commerce" and "Department of Commerce" are faintly visible.]*

*[Faint text at the bottom of the page, possibly a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>03903</div> <div>CERTIFICATE OF DEATH</div> <div>03896</div>									
1. DECEASED-NAME (Type or print) First Middle Last Joseph T. Tucker					2a. DATE OF DEATH Month Day Year March 23 1969			2b. HOUR 9 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 11, 1884		6. AGE (In years at birth) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.			
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Urbana		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route 2	
14. FATHER'S NAME First Middle Last Edward F. Tuckers Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Sallie Mull						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Miss Margaret Tucker, Route 2, Frederick, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days 20 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes.</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16, 1966</u> , to <u>MAR. 23, 1969</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>MAR. 23, 1969</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.									
22b. SIGNATURE <u>Ralph L. Michels M.D.</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>MAR 24,</u>	
22d. PHYSICIAN'S NAME (Type) Ralph L. Michels, M.D.				22e. ADDRESS Frederick Medical Center, Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 25, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick Frederick Md.</u>			
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03904

CERTIFICATE OF DEATH

03897

1. DECEASED-NAME (Type or print) <b>Walter</b>			First Middle Last			2a. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>69</b>			2b. HOUR <b>4:10A</b> M		
3. SEX <b>M</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>AUG. 19<sup>th</sup>, 1901</b>			6. AGE (In years lost birthday) <b>67</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Colorado</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Frederick</b> Md.		
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Painter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>self-emp.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Middletown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <b>Herbert</b> Middle <b>VanWestenberg</b> Last <b>VanWestenberg</b>			15. MOTHER'S MAIDEN NAME First <b>Cora</b> Middle <b>Unkn</b> Last <b>Unkn</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>---</b>			16b. SOCIAL SECURITY NO. <b>523-14-0488</b>		
17. INFORMANT Address <b>R.F.D.2</b>			17. INFORMANT <b>Vera Van Westenberg</b>			17. INFORMANT <b>Middletown, Md.</b>			17. INFORMANT <b>Middletown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4122</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive + Arterio sclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-10 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>---</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from <b>MAY 5, 1965</b> , to <b>MAR. 31, 1969</b> , that (I) (we) saw the deceased alive on <b>MAR. 30, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ralph L. Michels, M.D.</b> DEGREE <b>M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>APR. 1<sup>st</sup>, 69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Ralph L. Michels, M.D.</b>						22e. ADDRESS <b>Medical Center, Frederick, Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>April 2, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Middletown Fred. Md.</b>		
24. FUNERAL DIRECTOR <b>Gladhill Co. Middletown, Md. 21769</b>						25a. REC'D BY REGISTRAR <b>APR 3 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. Chmela, Judge</b>		

03806

CERTIFICATE OF DEATH

DIVISION OF PUBLIC HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH

1950



THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE COUNTY OF NEW YORK, IN THE CITY OF NEW YORK, IN THE YEAR 1950.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03905		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH		03898			
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR 8:10 P.M.	
Charles		Nicholas		Washington		March		23		1969	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 2-16-1890		6. AGE (In years last birthday) 79		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Water Dept		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 42 Carver Apt			
14. FATHER'S NAME John		First		Middle		Last		15. MOTHER'S MAIDEN NAME Mallissa		First Middle Last NMN Pratter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 117-10-9356		17. INFORMANT William E. Blackston		Address 42 Carver Apt, Fred, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia; generalized arteriosclerosis &amp; chronic congestive heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>17 MAR</u> , 19 <u>69</u> , to <u>23 MAR</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>23 MAR</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George I. Smith Jr		22c. DATE SIGNED 23 MAR 69		22d. PHYSICIAN'S NAME (Type) George I. Smith, Jr		22e. ADDRESS 804 Toll House Ave, Fred, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-26-1969		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Frederick Fred. Md					
24. FUNERAL DIRECTOR C.E. Hicks, 111 263 W. Patrick St, Fred, Md				25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

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Laurence Maffabey

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Robert J. Taylor

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George I. Smith Jr.

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FOR STATE  
HEALTH DEPT.

03906

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03899

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Harry Charles Wolfe, Sr						Month Day Year			Hour		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	Negro	12-26-1880	88 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			Hour
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Pa		U.S.A.		Frederick							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Adamstown			Park Mills Rd Rt 1			Blg Contractor			*****		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md			Frederick			Adamstown			Park Mills Rd Rt 1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Calvin NMN Wolfe			Ruth NMN Ricketts								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			*****			215-20-9857 Martha Wood			154-46th St N.E. Washing D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>											
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M.			19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED											
3-10-69											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
23b. DATE											
3-11-1969											
23c. NAME OF CEMETERY OR CREMATORY											
Fairview											
23d. LOCATION (City or Town) (County) (State)											
Frederick Fred. Md											
24. FUNERAL DIRECTOR											
C.E. Hicks, 111 Frederick, Md											
25a. REC'D BY REGISTRAR											
MAR 12 1969											
25b. REGISTRAR'S SIGNATURE											

MEDICAL CERTIFICATION

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Robert J. Thomas, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒  
ADDRESS (Street, city, town, or county)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT J. THOMAS, M.D.  
812 TOLL HOUSE AVENUE  
FREDERICK, MARYLAND

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